MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

September 13, 2002

Update on the 2003 hospital outpatient PPS proposed rule

ISSUE: On August 9, 2002, CMS released a notice of proposed rule making setting payment rates for the hospital outpatient PPS for calendar year 2003. A draft comment letter is attached.

KEY POINTS: The outpatient PPS classifies services into ambulatory payment classification (APC) groups for payment. Each APC has a relative weight. Payment is determined by multiplying the relative weight by a conversion factor. The payment system also has a pass-through payment mechanism that is designed to cover the incremental costs of expensive new technologies (drugs, biologicals, and medical devices) that are inputs to an existing service. A large number of items will lose eligibility for pass-through status on January 1, 2003.

In the rule, CMS proposes changes to the classification system, establishes new relative weights, integrates items that have lost pass-through eligibility into the base APC payments, and updates the conversion factor. For the first time since the outpatient PPS was implemented, the payment rates in the rule are based on claims data from hospitals operating under the outpatient PPS, paired with the latest available cost report.

The draft comment letter addresses the following issues, among others:

- In the rule, CMS establishes a new APC code and payment rate for insertion of drug-eluting coronary artery stents, a medical device that has yet to receive FDA approval but is expected to change cardiac care and diffuse quickly. Setting this rate demonstrates that CMS can react promptly to accommodate a break-through technology. It also shows that a national rate for a device can be established without the benefit of substantial hospital cost data.

- The integration of a large number of pass-through medical devices into the base APC payment rates makes the payment system less complicated and eliminates the negative incentives imbedded in the cost-based payment mechanism used to set pass-through payment rates.

- The integration of a large number of pass-through drugs and biologicals eliminates reliance on average wholesale price to set payment rates. However, the approach taken may create undesirable incentives because low-cost drugs are bundled into service-based APCs while high-cost drugs (those costing more than $150) are paid separately. Changes in payment rates for drugs will also lead to differences in payment for a number of drugs across settings. In general, payment for these drugs will be lower in hospital outpatient departments than in physicians' offices.

ACTION: Commissioners should provide feedback on the draft comment letter. The letter is due to CMS by October 7, 2002.

STAFF CONTACT: Chantal Worzala (202-220-3718)